By Dr Tan Chi Chiu

A New Network of Medical Relationships

Response to Speech by the Permanent Secretary for Health, Ms Yong Ying-I at Gleneagles Hospital's 8th Annual Seminar 2006

NEW THINKING

I would like to begin by thanking the Permanent Secretary for Health, Ms Yong Ying-I, for taking the trouble not only to open our Annual Seminar, but also to provide a substantive keynote lecture. As she admitted, the Ministry of Health (MOH) does not traditionally engage the private sector and she has demonstrated an encouraging shift in thinking, that the private sector is very much part of the national healthcare eco-system, and a major component of the national healthcare 'industry'. It is also refreshing to hear that MOH wishes to consult all sectors, because they admit that they do not know all the answers.

This major paradigm shift is significant because over many years, successive MOH administrations have regarded the private sector somewhat as a family outcast, albeit a wealthy one. The attitude was that doctors who left the public sector were somehow 'disloyal' to the system, that they were selfish and avaricious, disinterested in teaching and research and practised a brand of medicine that was less evidence based, but more designed to maximise profit. All these are unfair and incorrect views. I am happy that there is a growing recognition that there are many reasons doctors transit to the private sector, monetary gain not being anywhere near the top of the list, and the private sector remains a valuable resource of talent and ideas for the advancement of healthcare in Singapore. I applaud the Permanent Secretary's assertion that "In an era of rapid change and faced with competitive challenges from Thailand and Malaysia, there is benefit in our thinking together and collaborating together. We are in the same sector and on the same side; the enemy is out there."

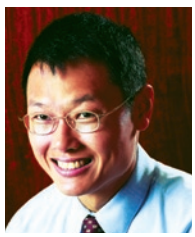
SINGAPOREMEDICINE

There has always been a modicum of private practice within public hospitals, primarily to give local patients choice. However, the role of the public sector was always overwhelmingly that of providing affordable healthcare, teaching and research. When public hospitals were 'restructured', the public sector over time took on many of the characteristics of private medicine, some would say even more aggressively commercial than the private sector itself. What are we to make of MOH's current thinking that although the private sector should take the lead in 'SingaporeMedicine', "the public sector should also participate more actively in this effort to develop ourselves as an international medical hub attracting patients from around the world"? In terms of technology and skills development, the public sector has always had the advantage of public funds to invest in new equipment, paid training time to learn new skills from abroad and a vast number of patients on whom skills will be perfected. The private sector is not sitting on its hands and is certainly not lagging behind, but it has the structural disadvantages of less ready financing for new machines, fewer patients, less structured services, less research capability and fewer training opportunities to develop new skills. It is not unfair to suggest that because the public sector in Singapore leads in many developments, they should market advanced treatments to the world.

In her speech, the Permanent Secretary implicitly admits that the Government is indeed competing with the private sector for business. It could be argued that just as Government Linked Corporations (GLCs) have realised that they should not compete with existing private businesses, and should apply what they call the 'yellow pages rule' to decide what businesses to enter, MOH should similarly not use public funds to compete with the private sector.

I think the private sector has no problem with the public sector competing for private and

Page 25 ►



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◀ Page 24 – A New Network of Medical Relationships

international patients per se. The trouble is that the competition is not on a level playing field. In other countries where public doctors have private practices, there is a firewall between the two. A doctor receives public pay and privileges (including annual leave) in strict proportion to the number of sessions a week he serves the public. The rest of the time is his own. He can rent premises, employ staff, pay overheads and keep his own accounts as a full-fledged part-time private practitioner. He is not covered for his absence in the public institutions by publicly funded juniors and certainly not assisted by juniors when engaged in private practice. It is a truly independent enterprise.

Although there is token separation, surprisingly this is nowhere near as comprehensive as it should be in Singapore when public doctors engage in active private practice. These doctors are already buffered from business risks, the effects of the economy and things like SARS by having a full and secure base pay and unmodified privileges. They do not also need a cushioned private practice. Further, although the original intent of this so-called 'faculty practice' was to retain good doctors in the public sector, what it has turned out to be is a very helpful publicly-funded bridge for public doctors to transit fully to the private sector if they wish, or to effectively have their cake and eat it as well while in public practice.

The market distortion caused by such subsidised private practice has a couple more side effects. In the past, it was accepted that private doctors took business risks that justified better returns in good times but sacrificed the benefits of paid vacations, conference leave, collegiality, the stimulation of research and so on. However, it has now become an article of faith of some public doctors that they deserve to have all the benefits of private practice, including incomes that often exceed their private colleagues, with none of the risks of business and all the benefits of paid research, conference time, annual leave, leadership positions and status. On top of this, some public specialists have expressed the view that the public sector should now lead SingaporeMedicine, not the private sector, representing an amazing turning on its head of the role of public institutions. What is more unhealthy is the development of a certain degree of megalomania in some pockets in the public domain, which views private doctors as inferior and having lesser rights than public doctors to practise certain advanced skills, an attitude couched as patient protection, but in reality turf and business protection.

Therefore it is reassuring that the Permanent Secretary has put things back into perspective by stating clearly that MOH still sees "the private sector as being the dominant player in SingaporeMedicine, treating the majority of patients. But [sees] the public sector hospitals serving some of these through private wings, distinct from the mainstream hospital blocks treating subsidised local patients". The question is, how distinct? There is an argument that institutions such as the Singapore General Hospital or the National University Hospital have brand names that would attract patients, so these institutions should be allowed to directly service overseas patients. This is a reasonable proposition. Public institutions could set up separate companies bearing their names but run with business discipline without subsidies. Commercial loans could be obtained, after which the companies must survive on their own. Even Singapore Airlines is able to refute competitors' accusations of government subsidy.

Better still, public institutions could enter into business partnerships with private groups like Parkway or Raffles, building co-branded specialist centres and thus concentrate limited resources into powerful collaborations that would bring the best brains (both management and professional) from the private and public sectors to bear on SingaporeMedicine. The public institutions can then focus on their core business of providing affordable healthcare to all without distractions.

The Permanent Secretary believes that it will be possible to bring into Singapore one million international patients by 2012. How this figure was arrived at and how it will be done was left unsaid. Of course one key limb of SingaporeMedicine is concerted marketing of our private services overseas. Here is where there should be a clear divide between private and public services again. At the moment, public institutions incur significant expenses marketing their services overseas at public expense. In the models suggested above, marketing will be part of the budget of independent private companies and not hidden within the overall expenses of public institutions.

The cost of services to overseas patients remains an issue. We are currently not competitive on price alone compared with medical services in Malaysia or Thailand. We must therefore find ways of reducing costs. But it will be impossible to match prices of our neighbouring countries because the cost of doing business in Singapore is simply higher. We must therefore provide value-added services and this involves pushing the frontiers of medicine so that we are at the forefront of knowledge, skills and technology. The investment that the government is making in clinical and translational research is therefore the correct strategy. Currently the private sector does very little research because it

Page 26 ▶

◄ Page 25 – A New Network of Medical Relationships

is not organised to do so. Specialist centres could be set up in the private sector to allow pooling of private patients for the purposes of research collaboration with the public centres. The most common model of private practice at present, that is, single-doctor clinics, does not permit this. In addition, it is an inefficient model with high costs. Hence there must be incentives given to private hospitals to set up clinical centres of excellence that concentrate expertise but reduce costs. Again, if done in collaboration with the private companies of public institutions, maximum benefit will accrue to all.

MANPOWER ISSUES

In anticipation of burgeoning patient numbers, MOH believes that there will be a worsening of the current manpower shortage amongst doctors, nurses and other ancillary staff. Apart from ramping up the medical student intake and starting a new medical faculty in partnership with Duke University, MOH and the Singapore Medical Council (SMC) have progressively lengthened the list of accredited universities from which graduates would receive immediate conditional registration to practise in Singapore, with the promise of full registration after a few years. Although not explicitly stated, one can imagine that a secondary aim is to bring about more internal competitive pressure so that private sector prices are reduced thus narrowing the gap a little between us and neighbouring countries.

There are several potential problems with this scheme. Firstly, medical migration tends to be from less developed to more developed countries, with the exception of headhunted world experts. On top of that, migration tends to be from countries where the standard of expertise and living are less satisfactory relative to countries where these are better. For as long as we are not yet at the top of the league for medical research and development and for as long as a junior doctor's lot here is not the best that it can be, when the majority of universities on the accredited list are from Europe, North America and Australasia, it is likely that Singapore will not attract large numbers, nor the very best doctors. Granted we can reject those who perform poorly, but a significant number of 'satisfactory' performers will still bring down the average standard. If such foreign doctors were to replace Singaporean doctors who have left for the private sector, then our subsidised patients will be cared for by a majority of foreign doctors with all the attendant problems of language and culture. When these doctors enter the private sector, hopefully there will be enough patients for all. But if the estimate for SingaporeMedicine proves overly optimistic, as many of us believe it is, then the private sector will be oversaturated. No doubt prices will moderate due to internal competition, but overall standards may also be compromised, especially if over-servicing occurs to compensate for lower margins. Thus, one of the fears expressed in the 1993 White Paper on Affordable Healthcare that led to the earlier capping of foreign graduates may actually be realised after all.

What would be helpful is for us to be able to titrate the influx of foreign doctors to our own needs and the growth of the medical 'industry'. I believe that preferentially attracting the very best from less developed countries around us (whose universities we tend not to recognise) will do us better, as there are many extremely bright and capable young doctors who may have limited opportunities in their own countries but who will thrive in Singapore. Similar thinking has brought top students from regional countries into Singapore schools on bonded scholarships. The way to achieve all of this may not be to have an ever changing list of accredited universities, but to have an entry examination through which a certain minimal standard can be ensured, where good candidates from currently 'unrecognised' universities have a fair chance to prove their worth and by which numbers can be regulated according to need. This option has been set aside in favour of direct recognition, ostensibly to reduce barriers to medical immigration. It is noteworthy that the entry examinations set by USA have not discouraged the legions worldwide that attempt to get in. Perhaps this option can be revisited if and when Singapore becomes attractive enough for top medical talent so that examinations are no object. Meanwhile, we continue to tweak our lists, operate multiple tiers of professional registration and create elaborate supervisory frameworks to try to get good foreign doctors into our system.

A NEW NETWORK OF RELATIONSHIPS

The concept of long-term care management, spanning the range from healthcare education, preventative medicine to treatment of established disease, is an excellent one and perhaps long overdue in receiving due attention. Improving clinical outcomes through evidence-based medicine and knowledge-based practice from primary to tertiary health services requires much emphasis on continuing education and training. GPs in particular have always complained that they have little free time for CME. This is often because of their long hours necessitated by competitive pressures and the need to make a reasonable living. Perhaps the solution to all of this lies in the new relationship envisaged by MOH between GPs and patients and between GPs and specialists, whereby coherent, integrated

Page 27 ►

◀ Page 26 – A New Network of Medical Relationships

and seamless management of all patients is possible. The first requirement is probably to fundamentally restructure primary healthcare on a national basis. The current system does not encourage patients to develop long-term relationships with GPs unlike in the United Kingdom under the National Health Service. Restructuring may require drastic changes to the landscape, such as bringing about a reorganising of at least some GP services by zones, with incentives to increase expertise and to form family practice groups for maximum efficiency. Next, MOH would need to encourage families to register with these GP groups and stick with them, perhaps through allowing Medisave usage only within such relationships. Rationalisation of GP services, reduction of multiple, redundant visitations, funding by Medisave and cost efficiencies all could allow a higher quality of GP contact, justify higher charges, increase margins and so reduce the need for GPs to work ridiculous hours with no holidays just to earn a living. This in turn allows GPs more time for patient education and for their own CME, to communicate better with specialists in providing joint care for patients, thus fulfilling MOH's vision.

What is left unsaid is whether there will be a shift to allowing the use of Medisave for specialist care only when referred by a GP. This is common in socialised medical systems, where GPs are the gatekeepers for specialist care. This would require patients to have great faith in their GPs. The Permanent Secretary bemoans the fact that public sector specialists are being swamped, while GPs are being underused. She did not say whether discouraging walk-in specialist patients through the control of Medisave is on the cards but it must surely have been discussed. Public specialists would certainly feel relieved, but their elation would be tempered by the knowledge that when they go private, there will be far fewer walk-in patients. Also, unless patients are confident about the care given by GPs, they will feel discriminated against compared to foreign patients because they are not allowed to use their 'own' Medisave money to see specialists directly if they wish. There are also potential problems of increased costs, since GPs need to be paid to write referrals, and a change in the GP-specialist relationship, when GPs hold specialists' rice bowls in their hands. There must therefore be some balance in the overall approach.

ELECTRONIC MEDICAL RECORDS

Finally a comment on national electronic medical records. The Permanent Secretary admits that the current state of IT does not allow more than limited information to be uploaded onto central servers, nor allow accessibility by all doctors anywhere in the country. Although not said, there is no doubt that patient confidentiality and medico-legal issues must also be solved. What has also not been discussed is how such a system will be implemented at the national level. Public institutions and outpatient clinics are easy to network and control, and may well have the luxury of clerks helping to input data, but what of private clinics? Not all doctors are computer literate or can even type. And how will patient confidentiality and security be ensured in private clinics? Double entry of information into case-notes and then into a computer will also consume more time. Whatever system is developed, it must be user friendly, secure, easy to roll out, economical and yet containing sufficient information for true seamless medical care to take place, between GPs and specialists and between the public and private sectors.

In many developing countries that I have worked in, a very simple system allows any doctor to have access to any patient's latest medical information. Patients carry little medical record books with them, updated each time they see doctors. It is low tech, portable and has the ultimate feature in patient confidentiality – a patient must voluntarily hand the book over to a doctor to read or write in. It occurred to me that patients could simply be given their own electronic 'medical files', readable and writable by special programmes that doctors could upload onto their computers. This would obviate the need for a huge central database accessed through the Internet with all the accompanying risks of information loss, leakage or abuse. Of course this solution may not be sophisticated enough for Singapore's aspirations, data for statistics and research would be hard to retrieve and of course patients could lose their files. I am sure that progress in IT will ultimately allow the perfect system to be implemented in Singapore.

CONCLUSION

In conclusion, the Permanent Secretary's message is both welcome and timely. If, and I have no reason to doubt this, MOH genuinely wishes to forge active partnerships with all sectors in policy development at a time when medical services in Singapore are facing numerous challenges both domestic and international, then we should all welcome this and look forward to more opportunities to give feedback, offer ideas and forge collaborations amongst the triumvirate of MOH, the public and the private medical sectors. I feel very optimistic that we can solve many problems together and make SingaporeMedicine the best it can be for our own population as well as for our international medical business. ■

The views expressed by the author are his own and do not represent the views of Gleneagles Hospital, or the Singapore Medical Council of which he is an elected member.